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PRIMARY HEALTH CARE QUALITY INDICATORS FOR A MORE SUSTAINABLE HEALTH CARE SYSTEM IN LITHUANIA

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Recent international research indicates that health care systems with stronger focus on primary care have better outcomes for less money than those with a strong focus on hospital care (Macinko, 2003; Starfield, 1998; 2005). This means that strong primary care increases sustainability of all health care systems. Nevertheless, when comparing different countries, the term primary care has different meanings and there are various forms of primary health care systems and providers. New challenges are ageing population, burden of chronically ill patients, new expensive technologies and increased overall costs of health care. Politicians and payers now more than ever are interested in efficiency and sustainability of health care systems in order to give best value for money.

The objective of the article is to summarize the existing primary health care performance indicators and list potential PHC quality indicators that would support a more sustainable health care system in Lithuania. This article is based on the "Improvement of public health by promoting equitably distributed, high quality primary health care systems" (ImPrim) project and the activities related to elaboration of an operational evidence system based and widely recognised as quality indicators for PHC performance. This study was prepared using relevant literature, websites, but also several e-mail contacts, phone calls, workshops, seminars and practices.

In summary, Lithuania health care quality needs to be assessed from the point of view of structure, process and outcomes. Such the stakeholders as patients, health care providers, professionals, financiers and also decision-makers (politicians) should be involved in the development and the selection of quality indicators. Good primary health care should not be limited to the diagnosis and the treatment of the presented problems but it has to demonstrate a comprehensive approach, patient centeredness, holistic approach, coordination of care and teamwork.

Keywords: primary health care, quality indicators, sustainable.
JEL codes: I180, I120, Q010.

Introduction

A. Jametona and C. McGuire (2002) believe that sustainability in health care involves balancing three key factors: 1) *The needs of patients.* The main responsibility of health professionals and institutions is to provide patients with competent, adequate, appropriate, humane care. Sustainable health care must respect the immediate needs of patients and the sense of responsibility and competence of professionals. 2) *Economic concerns.* Any sustainable institution must live within its income and in the long run pay its debts, costs of providing services, upkeep, and payroll. Thus, any proposal to consider budgeting values additional to patient care requires careful fiscal scrutiny. Expensive "green" health care would likely be available only to those with ample income and could not be practiced widely enough to make the health-care system sustainable as a whole. 3) *Environmental costs.* Health professionals also have an obligation to consider the environmental impact of their work. US health services generate about 4 billion tons of waste each year (Jameton, 2002). Research evidence is

collected from US and other developed countries, that increase of the number of the secondary health care specialists correlate with increasing health care expenditure and do not have any possitive impact on public health indicators. (Starfield, 2002, Doorslaer, 2004, Schoen, 2005, Shi, 2003). Only higher supply of primary health care physicians (family doctors, general practitioners) correlates with better health care outcomes, more rational use of health care resources and better natural environment.

Based on international evidence World Health Organization calls all countries in the world to strengthen their primary health care systems to improve effectiveness (better public health), efficiency (keeping costs manageable), equity (equal opportunity to get appropriate health care) and sustainability of health care systems (WHO, 2008).

Quality of primary health care and methods of assessing quality today are discussed as method for improving health care sustainability. The aim of quality work can be defined as the best structure, process and outcome of health care consistent with patient values and preferences, professional knowledge of appropriate and effective care, possible with given available resources (Mäkelä, 2001). Therefore measurement of primary health care (PHC) performance and introduction of new PHC performance indicators is a hot issue during the last decades in European countries.

Starting with the late 90's all countries in the Baltic See Region were trying to improve primary health care and implement reforms to rationalise their health care systems. Most intensive reforms were introduced in Estonia, Latvia, Lithuania, Poland and also in some Regions of Russia. These countries 20 years ago had the same Semashko organisational model: centralised health care with predominant hospital care, exaggerated role of narrow specialists and hospitals leading health care. From very beginning of transition all three Baltic countries and Poland declared strong plans to introduce family medicine and primary health care, but traditions of Semashko systems often served as an obstacle to have coherent reforms. Estonia demonstrated most successful story of primary health care reform among all former Soviet Union countries (Atun, 2006), nevertheless a lot positive lessons could be learned from all other countries in transitions including Belarus and Russia where reforms have started relatively later. Family medicine is not finally introduced in Lithuania and up to 30% of population have primary care provided by district internists and pediatricians, not retrained to family doctors.

Objective of the article is to overview the primary health care performance indicators used in Baltic See Regional (BSR) countries and to summarize potential PHC quality indicators for a more sustainable health care system in Lithuania.

Methodology. This article is based on the work done within the 2007–2013 BSR project "Improvement of public health by promoting equitably distributed, high quality primary health care systems" (ImPrim) and the activities related to elaboration of an operational evidence system based and widely recognised as quality indicators for PHC performance. This study was prepared using relevant literature, websites, but also several e-mail contacts, phone calls, workshops, seminars and practices. The authors of the article concentrate on the review of quality indicators used in BSR countries with special focus on indicators that measure organisational aspects, which are important for high quality primary health care (Starfield, 1998; WHO, 2008) like accessibility, continuity, first contact, comprehensiveness, community empowerment

and teamwork. The authors are aware that quality indicators used as quantitative quality control tools often have limitations to conclude on all the important primary health care organisational features. As an alternative to widely used external quality measurement tools, the authors present relatively new internal quality improvement tools applied in East European Countries.

Characteristics of high quality primary care

Organisation of primary health care varies between different countries in BSR. Family Medicine or General Practice (GP) is widely recognized as core discipline of primary health care with specific competencies, which are distinct from other medical specialties.

Despite of the different organizational forms primary care should provide functions as defined in B. Starfield's definition (1998): *primary care is first contact, continuous, comprehensive and coordinated care provided to populations undifferentiated by gender, disease, or organ system*.

Therefore high quality primary care should include following characteristics:

- first contact, easily accessible services for all population groups and addressing all health needs of the patient;
- provision of comprehensive services to meet the patients' needs with the focus on generalisation rather than specialization;
- provision of patient centred rather than disease centred care;
- provision of longitudinal relationship with the patients;
- coordination of care for individual patients;
- holistic approach, i.e. integration of biomedical, psychological and social dimensions of a patient's problem;
- focus on health promotion and disease prevention as well as management of established health problems.

Monitoring performance with internal quality improvement tools

For many years Nordic countries have been actively involved in international organisations, like The European association for quality in general practice/family medicine (EQUIP), which contributed to the development methods and tools for internal quality assurance. Quality assurance mainly represented in the form of the external control (audit) in Baltic States, Russia and Belarus contrasts with internal audit experience in the Nordic countries. Internal audit tools based on the demand for improvement of personal performance motivate primary care staff to act better without fear of being externally controlled or even punished.

One of internal quality improvement tools is APO (Audit projects Odense) method developed in early 1990th by general practitioners in Odense. Through Nordic audit network this method is used by a number of family doctors from Denmark, Sweden, Norway, Iceland and Finland (Munck, 2003). APO audit method helps to self-control your own performance in terms of topic selected by professionals using

quality indicators defined by them. Audit process consist of the following steps: 1) defining the problem area, 2) data collection and registration, 2) processing and analysis – very important to keep confidentiality: only average performance data should be visible and while the individual data would be accessible only by the respective individuals; 4) comparison and action – individuals compare their own data with average data (Strandberg, 2008).

Participation of Lithuania and Kaliningrad in EU financed project HAPPY AUDIT together with Sweden, Denmark and other countries and introduced possibilities to change attitudes of GPs towards respiratory infections treatment with antibiotics and serve as an example of international cooperation for quality improvement (Bjerrum, 2010).

Bilateral project between Stakes, Finland and St. Petersburg's Health Committee highly emphasize the training of all health primary health care professionals, leadership and management. The process of participatory workshops led to higher commitment of professionals related quality issues and the process of developing quality indicators was one of the most important outcomes of the whole project (Grouev, 2010)

Review of primary care quality improvement system in Baltic Sea Region

Estonia. Quality bonus system (Table 1) was implemented in 2005 and it is voluntary and gives an extra monthly fee (205–320 EUR) for a family doctor participating in the system. The main goal have been to promote the family doctors' active involvement in disease prevention, to tackle the spread of infectious diseases, to ensure more effective management of patients with chronic diseases and to motivate family doctors to provide a broad range of health services to the insured persons. Estonian health Insurance Fond has a financial database basing on International Classification of Diseases (ICD) 10 and health services provided by family doctors.

The number of family doctors participating in Quality Bonus system increased from 62% in 2006 to 90% in 2010. Proportion of insured persons who were involved with preventive care and follow-up activities increased by 36% during the period 2006–2009. Family doctors who participated in the project performed more preventive care and follow-up activities as compared to those who did not participate in it (for example individual consultations by family nurses, infant vaccinations, management of diabetes and essential hypertension). The indirect positive impact of the Quality Bonus system is the improved results of all family doctors (participants as well as non participants) throughout four years (Torvand, 2010).

Latvia. Quality indicators are approved by the MoH on the annual basis. Depending on the results of the evaluation undertaken by the Health Payment centre, half of the sum (for activity indicators) may be paid out monthly and the other half may be paid after a year in accordance with yearly quality indicators. PHC practices qualify for the monthly bonuses if their activity indicators (appointments per 100 registered patients) fall above the 0.75 minimum of the median calculated monthly for all PHC practices within the region, in which case they receive 50% of the bonus; and if they

satisfy PHC practice performance assessment criteria (working hours, patient waiting time, information quality) they receive the remaining 50% (Latvia HIT 2008).

Table 1. The Estonian bonus system

Prevention	• Immunization of the children in FD's list has to be at least 90% • Preventive check-up of the children – should be provided according to the guideline average at least 90 % of the children listed • Check up of the children before school – 90% coverage from all this age children listed • Primary prevention of the CVD (cardiovascular) risk of all 40–60 year old patients listed – 90% of all in this age group during 3 year
Follow-up of the chronic diseases	• Patients with hypertension – follow up according the guideline for FDs • Patients with diabetes type 2 (according the guideline) • Patients with myocardial infarction (according to the guideline) • Hypothyreosis (measuring TSH, checking up the medication) Coverage is calculated each year differently depending on the average level in Estonia and adding 10% more for the next year
Comprehensive care	To stimulate following procedures • Follow-up of pregnancies • Making common gynaecological procedures • Make minor surgery

Yearly quality indicators involve certain numbers of preventive interventions:

- number of registered patients seen during the year (to see 65% population annually of these registered);
- child health check-ups (ages 0 to 7) (at least 90% of registered);
- immunizations and vaccinations (90% of these from 3 to 14th vaccinated following plan);
- cancer prevention programmes;
- diabetes control;
- asthma control;
- ambulance visits to hypertension patients – 90% without ambulance calls of these who have hypertension.

GPs also receive fee-for-service payments for approximately 30 services (for example, strip tests, streptococcus test, electrocardiograms (ECG), pregnancy monitoring, small surgical procedures, etc.) and fixed allocations. Among the numerous fixed allocations, the most important are: PHC nurse/doctor assistant allowance according to number of registered patients. Doctors can choose two different options to work with one nurse or with two nurses. In case of two nurses doctors are getting higher allowance and also are able to shorten working hours for patients‘ consultation in the office (Lanka, 2011). There are practice allowances, which depend on:

- scale-dependent allowances indicator for a number of chronically ill patient visits (from hit 2008);
- density of the population in the catchment area;
- distance from practice to emergency post or number of children on the register.

Lithuania. Family doctors are gatekeepers and patients need referrals to all specialists, with the exception of dermatovenaerologist. Patients have to pay for the visit to secondary health care specialist (i.e. without referral from primary health care physician).

In Lithuania, implementation of the health care system with private independent contractors started in 1999 when EU PHARE project for the support of the PHC reform process announced competition for family doctors to establish private practices. In 2008 half of primary health care institutions were private.

Since introduction of new payment scheme from Mandatory Health Insurance in 2007, primary health care was reimbursed through age adjusted capitation fee. Until 2005 there were 4 age groups used: up to 5 years, 5–15 years, 16–64 years and 65 years and older. Since 2005–7 age groups were introduced: up to 1 year, 1–4 years, 5–6 years, 7–17 years, 18–49 years, 50–65 years, 65 years and older. Table 2 presents quality indicators for which bonuses are paid.

Finland has municipally salaried doctors who are getting monthly salary. Currently many different ways of contracts exist concerning salaries. There may be capitation parts in the salary but it also might include a part for procedures performed (e. q. injections to joints, puncture of sinus maxillaris, check up for some certifications, doing minor surgery, setting up an IUD (intra-uterine device) etc).

Outcome indicators are used in some primary health care centres but the quality bonus is usually paid for the whole primary health care centre not for individual professionals. These indicators may be waiting times, electronic communications performed between doctor/nurse and patient, preparing a suitable abstract of patient records and updating it, mini-interventions performed and recorded for alcohol or tobacco abuse, group counselling of patients having diabetes and some other chronic diseases. The quality of care is important but pay-for-performance system is not generally used.

In Swedish health care, there is a traditional and strong focus on fixed payment to both hospitals and primary care providers. Pay for performance is already used within Swedish health care, especially within primary care but to some extent also for hospital services because the national government allocates grants to the 21 county councils responsible for health care services. (Anell, 2009). In general, all employed doctors have a monthly salary without any components of pay-for-performance.

Table 2. Quality indicators used in Lithuania for bonus payment

Indicator	Numerator	Denominator	Bonus paid if
Population care coverage			
Child care coverage	Number of children (under 18) who visited family doctor at least once per year	Total number of listed population in this age group	90% or more
Adult care coverage	Number of adults who visited family doctor at least once per year 60	Total number of listed population in this age group	60% or more
Implementation of prevention programmes			
Cervical cancer prevention programme	Number of women participating in this programme – those who were informed and got PAP smear test with consultation	Total number of listed women participated in this programme	
Prostate cancer early diagnostics programme	Number of men participating in this programme those who were informed and checked PSA	Total number of listed men participated in this programme	

In Sweden increasing importance has been set to measure the quality of each primary care unit. These indicators are published on the Internet for the patient to compare and for politicians and professionals to improve the standard of the hospitals and primary care unit.

PHC quality indicators to support more sustainable health care system in Lithuania

Different understanding of primary health care role or a conception of what is strong primary care in some countries sometimes is in conflict with the internationally proved characteristics of strong primary health care. A payment system with quality indicators is perceived as an important part of a wider structure that influences the incentives and priorities across health care providers.

Performance-based quality indicators might powerfully improve the quality if they really measure good quality. The worst case may indicate that actual benefits for patients develops to the worse, while the documented quality at the same time indicate improvements. Health care providers are rewarded in the belief that improvements are made in spite of the fact that clinical practice develops in the wrong direction. Examples of that are when providers avoid complex patients for whom it is more difficult to reach defined performance targets or if services to patients become dominated by protocols and "box-ticking" rather than an interest for the patient's individual needs (Boyd, 2005; Anell, 2010).

Another example is preventive services and health counselling activities. The international research indicates that primary health care doctors and nurses could be

efficient in orienting consumers to live healthy and assess risks. Unfortunately, in East European countries doctor centred approach in health education is often met as traditional and very formal. Many practices disregard health education and counselling activities and focus merely on diagnostic and treatment activities.

Results found in APO-audit and powerful strategies are needed to spread such internal quality improvement tools as APO-audit and to foster primary health care practitioners' and nurses' responsibility to measure self performance and quality improvement. Financial incentives in East European countries could be used to motivate primary health care physicians and nurses to joint such quality improvement circles as APO Audit method.

To come with the list of successful indicators will be a difficult and sensitive issue. All the stakeholders such as patients, politicians, professionals and financiers should be invited to the discussion. The following techniques could be used in the selection process: consensus rating procedures, consensus development workshop, Delphi technique, nominal group technique, RAND appropriateness method. Gradual implementation and piloting indicators would be a good start. An enormous big package should not be implemented all at once but slow development may be the best approach. Population health needs with different priorities should be considered.

Quite few indicators are applicable, if there does not exist an advanced data collecting system available. The system should collect the information directly from patient records, national databases (databases of Patients Funds' and/or National Health Statistics) ministry of health and connect the information with the pay for performance system. The family doctor should not get extra burden of filling in forms for this purpose.

The existing payment systems are different and sometimes competing care providers receive the same payment irrespective of existing differences in the quality of services which involves risk if these systems are not changed (Anell, 2010). This fact will give the authors an obligation to present some quality indicators to be used in Lithuania.

Following the model of A. Donabedian (2005), three categories – structure, process, and outcome were introduced as the indicators to measure PHC performance in Lithuania (Table 3).

Table 3. Following indicators are proposed to be used in Lithuania

Indicators for the structure:
• Number of family doctors (after residency) per 10000 population • Average number of population listed per one PHC physician • Family medicine (community) nurses (after special training in family medicine and/or community nursing) per 10000 inhabitants • Total nurses working in PHC per 10000 inhabitants • Clinical guidelines for management of chronic diseases exist • Density of population around PHC practice • Geographic accessibility of PHC institutions • Longest distance to PHC institutions • Official patients fee for the visits to PHC doctors • Official patients fee for home visits;
Indicators for the process:
• Percentage of adult population seen by family doctors and/or nurse per year* • Percentage of children population seen by their family doctor per year • Percentage of children population seen by their family doctor and/or nurse • Percentage of children population seen by their family doctor and/or nurse for prevention • Percentage of adult population visiting secondary health care specialist at least once per year • Proportion of visits to PHC and total visits • Rate of the visits to PHC physicians per one inhabitant • Rate of the visits to secondary health care physicians per one inhabitant • Indicators for accessibility • Waiting time to see doctor if non-urgent • Waiting time to see doctor if urgent;
Indicators for the outcome – related with overuse of more expensive/higher levels of care:
• Emergency hospitalizations for asthma • Emergency hospitalization for diabetes • Emergency hospitalization for hypertension • Rate of ambulance calls per 1000 population • Percentage of population referred/self-referred to the secondary health care specialists.

* This indicator may have no evidence and may lead to unsustainable medicalisation but is acceptable when the population has to use family doctor's services instead of specialists.

Conclusions

1. In order to support health care sustainability in Lithuania, health care quality needs to be assessed from the point of view of structure, process and outcomes. In order to support health care sustainability in Lithuania, health care quality needs to be assessed from the point of view of structure, process and outcomes.

2. Such Lithuanian stakeholders as patients, health care providers, professionals, financiers and also decision-makers (politicians) should be involved in the development and the selection of the quality indicators. Professionals of all levels of health care, management and leaders should be trained in quality issues. Training in these issues, especially when provided in a participatory way, will give commitment and trust in the system. Training sessions also provide a commitment and a possibility to

influence the new system. Finally, feedback from the ground level workers is important too.

3. Measuring Lithuanian primary health care quality using same methodology as in the clinical medicine has limitations as primary health care has several dimensions that are challenging to be measured. Qualified primary health care should not be limited to the diagnosis and the treatment of the presented problems but it has to demonstrate a comprehensive approach, patient centeredness, holistic approach, coordination of care and teamwork. That is why simple checklists applied in clinical performance cases cannot be applied and used as indicators to sustain Lithuanian health care. In addition to clinical indicators, other characteristics of primary health care should be assessed at the same time. Facility exit questionnaires for the patients and general patient satisfaction studies should be applied to measure essential primary health care quality aspects, such as accessibility, patient centeredness, holistic approach, empowerment of the patients for self-care and patient satisfaction.

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PIRMINĖS SVEIKATOS PRIEŽIŪROS RODIKLIAI LIETUVOS SVEIKATOS PRIEŽIŪROS SISTEMOS DARNUMUI DIDINTI

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Santrauka

Sveikatos priežiūros sistema yra viena svarbiausių bet kokios gyventojų veiklos infrastruktūros elementas. Pastarieji tarptautiniai tyrimai rodo, kad ši sistema, orientuota į pirminę priežiūrą, yra pigesnė ir garantuoja geresnį rezultatą nei sistema, orientuota į stacionarinę priežiūrą. (Macinko, 2003; Starfield, 1998; 2005). Todėl gera pirminė sveikatos priežiūra padidina visos sveikatos priežiūros darnumą. Nežiūrint to, sveikatos priežiūros samprata įvairiose šalyse nėra vienoda, skiriasi pirminės sveikatos priežiūros sistemos ir paslaugų teikėjai. Visuomenė susidūrė su naujomis problemomis: gyvenimo trukmės didėjimu, chroniškai sergančių ligonių protrūkiu, naujomis brangiomis technologijomis ir didėjančiais sveikatos priežiūros kaštais. Politikai ir sveikatos priežiūros paslaugų mokėtojai, dabar nei bet kada seniau yra suinteresuoti sveikatos priežiūros sistemos efektyvumo ir darnumo didinimu.

Straipsnio tikslas – apibendrinti esamus pirminės sveikatos priežiūros teikimo rodiklius ir paruošti pirminės sveikatos priežiūros kokybės rodiklius Lietuvos sveikatos priežiūros darnumui didinti. Straipsnis paruoštas remiantis projektu „ImPrim“ ir plačiai pripažinta pirminės sveikatos priežiūros teikimo kokybės rodiklių sistema. Studija atlikta analizuojant su tuo susijusią literatūrą, žiniatinklius, taip pat elektroninius kontaktus, telefoninius pokalbius, praktinius užsiėmimus, seminarus ir pan.

Lietuvos sveikatos priežiūros kokybę galima didinti struktūros, proceso ir paslaugos (produkto) požiūriu. Pacientai, sveikatos priežiūros teikėjai, gydytojai, finansuotojai, taip pat politikai turėtų aktyviai dalyvauti kokybės rodiklių kūrime ir atrankoje. Kokybiška sveikatos priežiūra negali būti ribojama ligos diagnostika ir gydymu, bet turi būti visapusiška, orientuota į pacientą, remtis holistiniu požiūriu, koordinuota komandinio darbo priežiūra.

Raktiniai žodžiai: pirminė sveikatos priežiūra, kokybės rodikliai, darnumas.
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